3-1

HIV/AIDS, Gender, and Food Security in Sub-Saharan Africa

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Executive Summary

HIV/AIDS continues to spread across the world at a rapid rate, with close to 5 million new HIV infections in 2006 alone. Sub-Saharan Africa, the worst-affected region, is home to two-thirds of all adults and children with HIV globally. Southern Africa is the epicenter of the epidemic—one-third of all people with HIV globally live there and 34 percent of all deaths due to AIDS in 2006 occurred there (UNAIDS 2006). This case study examines the spread of the epidemic and its impact on food insecurity through a gender lens.

The UNAIDS *Report on the Global AIDS Epidemic* (2004) warned that one of the biggest challenges of the coming years is "the female face of the epidemic" (p. 3). Globally, and in every region, more adult women (15 years or older) than ever before are now living with HIV (UNAIDS 2006). Peter Piot, executive director of UNAIDS, said that women are more vulnerable to the disease because of both biological factors (female genitalia are more susceptible to the disease than male genitalia) and sociocultural factors affecting sexual practices (Sopova 1999). The 17.7 million women living with HIV in 2006 represented an increase of more than 1 million compared with 2004. Across all age groups, 59 percent of people living with HIV in Sub-Saharan Africa in 2006 were women (UNAIDS 2006).

Women face a double threat. First, women have less access to accurate information about AIDS and, usually, even less power to enforce prevention techniques such as the use of condoms during sex. Second, women bear the brunt of the epidemic because they are responsible for taking care of sick relatives. Girls often drop out of school, lose jobs, and face stigma and discrimination when they care for HIV-infected relatives and friends (Sopova 1999).

Furthermore, women form the backbone of the agricultural labor force in Sub-Saharan Africa, and their vulnerability to the disease is associated with a drop in agricultural productivity and a deepening of the food insecurity endemic to Sub-Saharan Africa (FAO 2005). The UNAIDS report of 2005 stated that the epidemic is increasing labor bottlenecks in agriculture, increasing malnutrition, and adding to the burden on rural women. HIV/AIDS aggravates tenure insecurity owing to gendered power relations, population pressure, and stigmatization. The effect of the epidemic on women also affects the quality of life of the survivors of the epidemic, since women are normally the providers of care and prepare the meals consumed by other members of the household.

The effect of HIV/AIDS on food security is progressive, because the virus not only aggravates household food insecurity, but also spreads faster when people are malnourished and forced to adopt more risky food-provisioning strategies owing to their worsening poverty (Gillespie and Kadiyala 2005). Thus a vicious circle progressively worsens the conditions of people who are food insecure to start with.

Given the rapid spread of the epidemic, increasing food insecurity, and increasing gender inequalities in Sub-Saharan Africa, your assignment is to recommend policies that will enhance awareness of HIV/AIDS among all groups, reduce women's vulnerability to the disease, and improve food security.

Background

> *If scientists fail to cure AIDS, the epidemic will become a soft nuclear bomb on human life.*
> —Kenneth Kaunda, former president of Zambia.

Currently, approximately 40 million people are living with HIV/AIDS. In 2006 alone, there were close to 5 million new HIV infections worldwide and 2.9 million AIDS deaths (UNAIDS 2006). AIDS epidemics are multidimensional, long-term, and phased phenomena that act in waves. The first wave is the HIV infection itself, followed by a wave of opportunistic infections (such as tuberculosis), leading to AIDS illness and death. Finally, there is an accumulation of macroeconomic and social impacts at the household, community, and national levels (Gillespie 2006b).

The worst-affected region is Sub-Saharan Africa, which was home to 24.7 million people living with HIV in 2006. Approximately 2.1 million people died of HIV-related illnesses in Sub-Saharan Africa in 2006, accounting for almost three-quarters (72 percent) of all adult and child deaths due to AIDS in 2006. A further 2.8 million were infected with the disease in the same year (UNAIDS 2006).

The literature and information on AIDS in Sub-Saharan Africa warns against considering the disease an "African epidemic." There are multiple epidemics, and their spread varies hugely between countries and sometimes even within countries. The 2005 UNAIDS report said that three Sub-Saharan countries—Kenya, Uganda, and Zimbabwe—had shown a decline in national adult HIV prevalence in 2005. It is important to be cautious, however, when interpreting prevalence figures because they can yield ambiguous and confusing pictures of the epidemic. HIV prevalence describes the total number of people living with HIV, irrespective of when they were infected. Thus, in areas where the epidemic is intense and mature, the stabilization of HIV prevalence, instead of indicating a slowdown in the spread of the epidemic, could simply mean that the numbers of people being newly infected with HIV and the numbers dying of AIDS are roughly equal. Only in Zimbabwe did both HIV prevalence and incidence fall (UNAIDS 2005).

The changes in Zimbabwe are attributed to changing sexual behavior, dating from the mid- to late 1990s, brought about by specific HIV-related interventions. These behaviors include a decrease in the number of sexual partners, later sexual debuts, and an increase in condom use within casual partnerships—86 percent of men and 83 percent of women in Zimbabwe use condoms during sex (UNAIDS 2005). Nevertheless, approximately one in five adults in Zimbabwe is living with HIV—one of the worst HIV epidemics in the world. The estimated average life expectancy at birth for women and men in Zimbabwe is 34 and 37 years respectively (WHO 2006).

Why a Gender Lens?

The number of women contracting the HIV virus continues to rise at alarmingly high rates. In 2006, 17.7 million women worldwide were living with HIV—an increase of more than 1 million from 2004. In Sub-Saharan Africa, for every 10 men infected with HIV, about 14 adult women are infected with the virus (UNAIDS 2006). Women are more vulnerable to the disease because of both biological factors (female genitalia are more susceptible to the disease than male genitalia) and sociocultural factors affecting sexual practices (Sopova 1999).

One of the main reasons for this rising trend is women's lack of knowledge about transmission and prevention. Furthermore, many women have low social and socioeconomic status and therefore do not have access to information on HIV/AIDS, which is often more readily available to men.

The increased vulnerability of women to the HIV/AIDS epidemic is also a reflection of existing gender inequalities as men usually hold a disproportionate amount of power within sexual relationships. Gender inequity shapes power and sexual relations as well as access to resources such as land (Gillespie 2006b). Women hold a subservient status in many Southern and Eastern African countries, and HIV/AIDS exacerbates these inequalities (UNAIDS 2005). Practices such as genital mutilation and dry sex increase women's risk. Often, women's lack of power within a relationship does not allow them to negotiate safe sex practices with their male partners. Women's low levels of knowledge increase their vulnerability to the disease (Glick and Sahn 2005b). The emphasis on virginity and the silence surrounding sex restricts girls' access to information about sex and heightens the risk of sexual coercion (Gupta et al. 2003 as cited in Gillespie and Kadiyala 2005). The male-disseminated notion that sexual intercourse with a virgin can cure HIV/AIDS is an example of how male dominance can affect the spread of the virus (UN 2006b). Violence against women is often used as a tactic of war—in many conflicts, this has included the planned and purposeful infection of women with HIV, often pitting one ethnic group against another, one such example being the conflict in Rwanda in 1994 (UNIFEM 2006; available at http://www.unifem-eseasia.org/resources/factsheets/UNIFEMSheet5.pdf).

Vertical transmission of HIV from mother to infant, which can occur during pregnancy, during delivery, or through breast-feeding, is a major pathway for the continuing spread of the disease

(Gillespie and Kadiyala 2005).[1] Maternal HIV status is associated with increased mortality among young children. For example, in Tanzania the mortality rate among children under two years of age born to HIV-positive mothers is 2.5 times higher than those born to HIV-negative mothers (Urassa et al. 2001). Women also have limited access to health care and frequently wait longer than men before visiting health facilities (Prins et al. 1999 as cited in Gillespie and Kadiyala 2005).

Knowledge of HIV transmission and prevention is key to preventing the spread of the HIV virus. Yet in Sub-Saharan Africa only 8 percent of out-of-school young people and slightly more of those in school have access to education on prevention (UNAIDS 2004). Education, both primary and secondary, is strongly correlated with a woman's prevention knowledge. For example, young women in Rwanda with secondary or higher education were five times more likely to know the main HIV transmission routes than were young women with no formal education (WHO, UNAIDS, and UNICEF 2004). Educated women are more likely to know about preventive techniques and have fewer misconceptions about transmission. A woman with a completed primary education is twice as likely as a woman with no schooling to know one or more means of HIV prevention, irrespective of whether she is from a rural or urban area (Glick et al. 2004). This result underscores the need to make HIV messages more accessible to women (Glick and Sahn 2005b).

Economically, women's dependence on men and their unequal access to resources, including land, increases their risk of contracting the disease. Low socioeconomic status increases the likelihood of a woman's exchanging sex for money or goods and raises female chances of experiencing coerced sex and the odds of having multiple sexual partners. In addition, it lowers female chances of abstinence, female and male age of sexual debut, the likelihood of condom use at last sex, and women's communication with their most recent sexual partner about sensitive issues (Gillespie and Kadiyala 2005).

Furthermore, women form the backbone of the agricultural labor force in Sub-Saharan Africa, and their vulnerability to the disease also leads to a drop in agricultural productivity and a deepening of the food insecurity that currently exists in Sub-Saharan Africa. The 2005 UNAIDS report states that the epidemic increases labor bottlenecks in agriculture, increases malnutrition, and adds to the burden on rural women. HIV/AIDS aggravates tenure insecurity owing to gendered power relations, population pressure, and stigmatization. The epidemic also affects the quality of life of the survivors of the epidemic.

The Impact of HIV/AIDS on Food Security

The epidemic has decimated a large proportion of the labor force, causing a mismatch between human resources and labor requirements. It is estimated that the size of the labor force in Sub-Saharan Africa will be 10 to 30 percent smaller by 2020 than it would have been without AIDS (UNAIDS 2005).

The epidemic has also further exacerbated the struggle for food security. Oftentimes, the epidemic claims the working members of the family, which drastically changes household composition and has resulted in a rapidly growing orphan population (Evans and Miguel 2004). This decline in the working-age population has led to a decrease in area being cultivated, less labor-intensive cropping patterns and animal production, and an increase in fallow land returning to bush. Families have been forced to sell their lands, slaughter their livestock for health care and funeral expenses, and accept lower incomes (FAO 2005). This loss of savings, cattle assets, draft equipment, and other assets may pose the greatest limits on rural productivity and livelihoods for these communities (Jayne et al. 2005 as cited in Gillespie 2006c). "When you ask people living with AIDS in rural communities in the developing world what their highest priority is, very often the answer is food" (Piot and Pinstrup-Andersen 2002, 1).

HIV/AIDS has eroded all forms of capital—human, financial, social, physical, and natural. Premature illness and death have reduced human capital and

[1] Gillespie and Kadiyala (2005) is a comprehensive review drawing on a detailed evidence base of more than 150 studies encompassing various disciplines. It helps build a picture of what is known about the interactions between HIV/AIDS and food and nutrition security and what this knowledge implies for policies relevant to food and nutrition. Because of the considerable overlap between that review and this case study, as well as the comprehensive nature of the research areas covered by Gillespie and Kadiyala, this study draws extensively on their work.

fractured the intergenerational transfer of knowledge. Social capital is under tremendous strain owing to HIV-related stigma and exclusion, increased orphan rates, and reduced incentives for collective action. Women often bear the brunt of the HIV/AIDS epidemics as the task of caring for the sick and dying falls on their shoulders, usually in addition to their other household and child care responsibilities. Expenditures for health care and funerals have eaten into financial capital, and physical and natural capital is being undermined as labor losses affect the ability to farm and force families to sell assets (Gillespie and Kadiyala 2005).

The effect of HIV/AIDS on food security is progressive, since the virus not only aggravates household food insecurity, but also spreads faster when people are malnourished and forced to adopt more risky food-provisioning strategies owing to their worsening poverty (Gillespie and Kadiyala 2005). Thus a vicious circle progressively worsens the conditions of people who are food insecure to start with. In this situation too, women—usually poor women—are the ones most adversely affected by the inability to provide food for their families and themselves. The United Nations has highlighted concerns regarding the "triple threat" of food insecurity, AIDS, and deteriorating capacity (UN 2004 as cited in Gillespie and Kadiyala 2005).

A study by Bryceson and Fonseca (2005) focuses on the collapse of the peasant household as a unit of production owing to shifts in household assets and livelihood portfolios. They highlight three significant changes, all of which affect women disproportionately. First, there has been a shift from self-sufficient unpaid labor within the household (usually carried out by women and children) to cash-earning piecemeal work. Second, with food production severely hit, there has been a shift to nonagricultural work, especially in the trade services—including sexual services. Third, all members of families are forced to work to earn enough money for basic subsistence needs. As women and children go farther out of their villages to find piecemeal work (also called *ganyu*), they are often at risk, as transactional sex is increasingly incorporated into *ganyu* contracts (as cited in Gillespie and Kadiyala 2005).

HIV/AIDS and Food Crises

The 2001–2003 food crises in Southern African highlighted two pertinent questions:

1. How does HIV/AIDS contribute to food crises?
2. What does the interaction between HIV/AIDS and food crises imply for the types of responses that are required?

Factors that aggravated the food crises included deep and widespread poverty, civil strife, insecurity about land (in Zimbabwe), removal of price controls, resource degradation, erosion of agricultural diversity, poor governance, and the repression of the press and civil society (Loevinsohn and Gillespie 2003 as cited in Gillespie and Kadiyala 2005). The region that was affected by the food crises also had the highest rates of HIV infection in the world, and there is growing recognition that HIV/AIDS has increased the vulnerability of agrarian society, enabling small shocks to cause crises for many people (Gillespie and Kadiyala 2005).

The depth of the crises in Southern Africa during the 2001–2003 drought and the distress it provoked were caused by three main factors: economic failure, the impacts of HIV/AIDS, and specific food policy failures (Wiggins 2005). Studies have argued that disasters should not be considered separate from everyday life since the risks involved in disasters are rooted in everyday vulnerabilities and are as much a product of social, political, and economic environments as they are of natural events per se (Wisner et al. 2004). Data from emergency food-security assessments conducted in Malawi and Zambia (in August and December 2002) and Zimbabwe (in August 2002) seem to suggest that the impacts of HIV/AIDS on food security during the 2002 food emergency were strong, negative, and complex (SADC FANR 2003 as cited in Gillespie and Kadiyala 2005), demanding a rethinking of policy responses.

Policies and programs to offset famine shocks and losses need to be reformulated in light of the AIDS pandemic. An AIDS-affected famine is different from the pre-AIDS famines because it kills not just the weak and vulnerable, but also the strong and able-bodied. This difference will have particularly severe consequences for women, who have greater domestic and external work burdens than men and

are more likely than men to become infected by HIV since they are more susceptible and therefore more likely to die sooner (Gillespie and Kadiyala 2005).

Current Situation

There is an increasing understanding that national responses to HIV/AIDS need to be grounded in strategic frameworks. UNAIDS has proposed the "Three Ones" commitment, which states that every country should have one HIV/AIDS strategy, one HIV/AIDS commission, and one way of measuring and reporting progress. Similarly, the United Nations system has proposed a systemwide response that includes 11 high-priority programmatic and 11 institutional actions (UN 2004 as cited in Gillespie and Kadiyala 2005). Because of the many hundreds of international development organizations currently engaged in the delivery of goods or services relating to HIV/AIDS, however, in countries with limited or nonexistent capacities, the result is an "implementation crisis—available resources are not being used, and the epidemic continues to outpace the response" (UNAIDS 2005 as cited in Shakow 2006, 12).

In fact, most of the current HIV/AIDS prevention, care, and treatment programs are not large scale and have been referred to as "expensive boutiques" because they are available to only a small percentage of the affected population (Binswanger 2000 as cited in Gillespie and Kadiyala 2005). Agricultural and labor policies have not changed sufficiently to accommodate the devastating effects of the epidemic on the labor force and the vulnerability caused by food insecurity. To date, the bulk of the response has been from the health sector, although up to 80 percent of the people in the most-affected countries depend on agriculture for subsistence (FAO 2005).

Food and nutrition security are fundamentally important to the prevention, care, treatment, and mitigation of HIV/AIDS because food insecurity and malnutrition raise the risk of HIV exposure and infection. Rising prevalence rates and the subsequent loss of labor also cripple the agricultural system. Thus, a "program of care without a nutritional component is like a leaky bucket" (Gillespie and Kadiyala 2005, 81). The FAO (2006) says that the agricultural sector cannot "continue with 'business as usual' in communities where vast numbers of adults are dead, leaving only the elderly and children. It has to revise the content and delivery of its services, as well as the process of transferring agricultural knowledge." (Available at: http://www.fao.org/hivaids/).

Through all these responses, gender is factored in but is not fully integrated (that is, the gender lens is not applied) except in programs to prevent mother-to-child transmission. Given women's documented vulnerability to HIV/AIDS due to cultural, social, and physical factors, there is a need to apply to the gender lens to programs that deal with the epidemic.

Stakeholders

Households

The literature on how the epidemic affects households in different income brackets is inconsistent and varies between countries. The common belief is that poverty is intrinsically linked to vulnerability to the disease, and thus to higher prevalence rates (World Bank 2006a; UNAIDS 2006; FAO 2006b). This pattern holds true consistently in some countries such as Malawi, where poverty and HIV risk seem to be increasingly linked as major livelihood shifts take place. Chapoto and Jayne (2005) found that in Zambia, however, the wealthy are the most susceptible to the disease, with 44 percent and 23 percent of upper-income men and women, respectively, more likely to die of disease-related causes than men and women from low-income households (as cited in Gillespie and Kadiyala 2005).

AIDS is decimating entire generations of productive young adults, leaving behind a huge cohort of orphans who do not have adequate community support, who are vulnerable to exploitation, and who lack education and livelihood opportunities. Among adults 15 years and older, young people (15–24 years of age) accounted for 40 percent of the new HIV infections in 2006 (UNAIDS 2006). Malnutrition is also on the rise among AIDS-affected households, especially among orphans and other vulnerable children. The response to this deteriorating situation in Sub-Saharan Africa remains inadequate. Even in a progressive country like Uganda, the combined efforts of nongovernmental organizations (NGOs), governments, and

donors currently reach only 5 percent of the 1.7 million orphans in the country (Gillespie and Kadiyala 2005).

In a cross-sectional survey of 119 households in the Rungwe district of Tanzania, Mwakalobo (2003) found that households that experienced an AIDS death spent substantially less on food than other households and had an increased probability of falling below the poverty line (as cited in Gillespie and Kadiyala 2005).

Widespread sale and slaughter of livestock in order to pay for medical and funeral costs are also found to have a detrimental effect on crop production. Research in Uganda showed that 65 percent of AIDS-affected households had to sell property to pay for health care (FAO 2001). This situation has led to a decrease in farm activity, and the role of the male household member as the primary income earner is eroding. Increasingly, rural women earn cash from sales of prepared snacks and beer, hair plaiting, petty retailing, knitting, tailoring, soap making, midwifery, and prostitution (Gillespie and Kadiyala 2005). The latter activity further increases their vulnerability to HIV infection.

The following sections describe the disaggregated impacts of the HIV/AIDS epidemics on different members of the household and the community.

Women

Gupta et al. (2003) conclude that the social and economic status of women is one of the most important factors—and possibly the most important factor— contributing to the spread of HIV and the ability of households and communities to withstand its implications (as cited in Gillespie and Kadiyala 2005). Yet current inheritance laws and customs in patrilocal villages have negative consequences for women and AIDS-affected households. Widows lose some or all of their assets, and this loss drastically changes the household composition and leaves widows and orphans destitute and even more vulnerable to HIV/AIDS and food insecurity. For example, in central Malawi, a newly widowed woman is expected to leave her husband's village and has no control over land and other assets (Shah et al. 2001). The death of the husband thus often leads to the dissolution and relocation of the household.

Men

Peter Piot, the executive director of UNAIDS, said that the roots of the AIDS problem lie mainly in poverty and male chauvinism and that it is necessary to change the sexual culture among young boys in order to change individual behavior. He acknowledged that this is going to be a slow process (Sopova 1999).

In many African societies, the sexual culture is such that men often engage in extramarital sex or buy commercial sex. Thus, women's own fidelity or monogamous sexual practices are not always enough to protect them against HIV infection. One of the growing demographic groups among women contracting the disease is housewives. Among women surveyed in Harare (Zimbabwe), Durban, and Soweto (South Africa), 66 percent reported having only one lifetime partner. Yet 40 percent of young women were HIV positive (Meehan et al. 2004 as cited in UNAIDS 2005).

HIV prevention is further complicated by general disapproval toward condom use. Many women, especially married women, are unwilling to use condoms because they do not believe it is "right" to do so (Slonim-Nevo et al. 2001). Furthermore, many men, especially married men, are opposed to using condoms during sexual relations, even if they are engaged in commercial sex or in an extramarital affair. For example, in rural Ghana, most single men disapprove of the use of condoms during sexual relations. They do, however, condone HIV testing before marriage. In contrast, both married men and women in rural Ghana oppose the use of condoms in sexual relations and HIV/AIDS testing before marriage (Aheto and Gbesemete 2005).

To change the gendered power dynamics in African society, including laws regarding land tenure and inheritance rights, it is essential that men be involved in the movement to reduce the gender imbalances and to fight HIV/AIDS as a community.

Vulnerable Children Affected by HIV/AIDS

In 2005, of the 3 million people who died of AIDS-related diseases, more than half a million were children. More than 12 million children in Sub-Saharan Africa had been orphaned by AIDS by 2004, the equivalent of one in nine children in that region (UNAIDS 2004). The orphan population is

constantly growing as HIV-positive parents become ill and die from AIDS. The quality of life for orphaned children is very poor because many of them are malnourished and unable to attend school. In Zambia, for example, children of AIDS-affected families in urban areas are likely to drop out of school because their caregivers do not have the funds available for school fees; in rural areas they might be required to work in the fields (Nampanya-Serpell 2000).

The type of orphanhood—maternal or paternal—seems to matter. For example, in Indonesia, the probability of being malnourished for maternal orphans was only 15 percent that of paternal orphans. Also, the impact of maternal orphanhood is severe regardless of household assets, whereas the impact of paternal orphanhood is felt only in poor households (Gillespie and Kadiyala 2005).

Millions more children are living with chronically ill parents, and about 3 million are themselves infected with the virus. Households with more than one orphan are 3.2 times more likely to report food insecurity and hunger than households with only one orphan or no orphan at all, taking into account potential confounders (Rivers et al. 2005). It is possible that with the rise in mortality rates, more households will face a decision about whether to foster more than one orphan or leave them to fend for themselves (Gillespie 2006b).

Sub-Saharan African Governments

Although a number of African governments have pledged to initiate programs to counter HIV/AIDS and have put together comprehensive, multisectoral AIDS strategies, there is still an implementation lag (Gavian et al. 2005). A 2003 UNAIDS survey in 63 countries found that only 13 percent had actually begun the process of implementing sectoral plans (Gillespie 2006b). In a 2006 talk at Cornell University, Jeffrey Sachs said that health budgets in Sub-Saharan Africa are only US$5–US$10 per person per year and that programs are often understaffed, leading to an absence of ground contact between health officials and individuals.[2] Most important, there are no agricultural policies in place that account for the devastation that the AIDS pandemic has wreaked on households and agricultural productivity.

[2] Jeffrey Sachs gave a talk at Cornell University on May 19, 2006, at which the author of this paper was present.

Donors, Aid Agencies, and NGOs

In the past 5 to 10 years there has been a huge upsurge in the number of international organizations providing HIV/AIDS-related services in Sub-Saharan Africa, yet because there is a lack of public health capacity to handle these burgeoning services, many of them have failed to implement successful programs (Shakow 2006). Much research has been undertaken to understand the impact of the epidemic, but less has been done to operationalize these findings and to implement measures to counteract the impact. Global development targets and goals have been agreed on without taking into account the added challenges of sharp increases in AIDS-related adult mortality rates in most of Africa and in parts of other regions, as well as the disaggregated impacts on the different members of households (UNAIDS 2005). Although gender equity is center stage in the dialogue about HIV/AIDS (see UNAIDS 2006), it is unclear whether and how the root causes of gender inequality, which are exacerbating the spread of the HIV/AIDS epidemic, are being addressed. Gillespie (2006b) maintains that although the rhetoric might be there, multisectoral responses remain thin on the ground.

Policy Options

There is a recognized need for a continuum or web of mutually reinforcing responses to the AIDS pandemic (UNAIDS 2004; World Bank 2004). The three core pillars of AIDS policy are (1) prevention, education, and awareness (reducing HIV transmission); (2) mitigation (reducing the impact of HIV and AIDS and supporting orphans and vulnerable children); and (3) care (providing direct support to people living with HIV and AIDS and their families) (UNAIDS 2006). At the "International Conference on HIV/AIDS and Food and Nutrition Security: From Evidence to Action" organized by the International Food Policy Research Institute (IFPRI), there was a consensus that a three-pronged strategic approach was needed: to strengthen household and community resistance and resilience, to preserve and augment livelihood opportunities for affected communities, and to ensure there are safety nets in place for those who need them (Gillespie 2006b). Programs aimed at improving the physical, economic, social, and spiritual well-being of people with HIV may also reduce transmission risk (Gillespie and Kadiyala

2005). Some comprehensive policy options are outlined here.

Addressing Gender Imbalances

In their review of existing approaches to addressing gender in HIV/AIDS-relevant programming, Gupta et al. (2003) outlined a continuum of approaches that have been used:

1. interventions that, at a minimum, do no harm;
2. gender-sensitive interventions that recognize that men's and women's needs often differ and find ways to meet those needs;
3. gender-transformative interventions that not only recognize and address gender differences, but also foster conditions in which women and men can examine the damaging aspects of gender norms and experiment with new behaviors to create more equitable roles and relationships; and
4. structural interventions that reduce gender inequalities by empowering women and girls; by increasing women's access to economic and social resources, such interventions can fundamentally change the economic and social dynamic of gender roles and relationships and, in the long term, protect women as well as men and families in the HIV/AIDS epidemic.

Gupta et al. conclude that gender-sensitive programs may address vulnerabilities in the short term, but ultimately transformative and empowering programs are required to challenge the root causes of the epidemic.

The UNAIDS 2004 report recommends action in five key areas to improve women's socioeconomic position and reduce gender inequality:

1. document women's land and housing rights and tenure security in areas of high HIV/AIDS prevalence;
2. raise public awareness, especially among national policy makers and donors;
3. reform legislation, including customary law and practice;
4. identify strategic litigation opportunities, especially by improving legal skills, stabling legal precedents through test cases, improving the court system, and ensuring women's access to legal structures and processes; and
5. identify and support experimentation within communities to change economic and institutional arrangements, including initiatives that support collective ownership or lease rights to land and that establish land trusts for orphans.

Prevention messages targeted to women must change completely. Many women in monogamous relationships believe they are not vulnerable to the disease. Yet the sexual culture is such that even women who are married or are in monogamous relationships are not protected against HIV infection. It is vital to use existing social and communication networks in order to ensure that both men and women are able to receive and act upon prevention knowledge.

Social interactions, especially between women, inform their beliefs and actions. Low-Beer and Stoneburner (2004) argue that in Uganda—the only country to have seen sharp falls in prevalence rates—social interactions played a positive role in containing the epidemic. This assertion is supported by Helleringer and Kohler's (2005) study in rural Malawi, which showed that social interactions on the subject of HIV/AIDS have significant and substantial effects on perceptions of HIV/AIDS risk (as cited in Gillespie and Kadiyala 2005). Though societal interactions vary by sex, region, and marital status, in general they are a resource for individuals to learn about and evaluate new behavioral strategies in the face of the epidemic.

Prevention messages targeted to women need to tap into these existing social networks, perhaps through community meetings, health counseling for women, and other such social interactions. The prevention message needs to emphasize not only the importance of safe sex, but also the importance of open communication about sexual relations with their husbands/partners. These networks should also encourage HIV testing.

Addressing the Security of Orphans and Vulnerable Children

More than one in nine children in Sub-Saharan Africa is orphaned (UNAIDS 2004). There have been some scattered efforts to improve the situation of orphaned children and children affected by the epidemic in Africa. For example, the STEPs program, a community-driven approach to scaling

up HIV/AIDS interventions, works with 20,000 orphans in Malawi. Started in 1995, it is supported by the U.S. Agency for International Development (USAID) and Save the Children USA. In Zambia, the government, NGOs, and the United Nations Children's Fund (UNICEF) have collaborated to establish the Children in Need Network (CHIN), which works for economic empowerment for households through programs, training, and income generation. World Vision assisted community members in setting up 10 community-based childcare centers in Nthondo, Malawi.

One of the real concerns regarding orphans is their inability to stay in school owing to lack of funds. With the rise in the number of children orphaned because of the loss of their parents to AIDS, class enrollments have sharply decreased. One in two orphans drops out of school (UNAIDS 2004). The educational system itself has been crippled by the AIDS epidemic. AIDS has a negative impact both on the supply of teachers and on the capacity of children to continue in school. Teachers are dying, and the teaching force is depleted as quickly as new teachers can be trained (UNICEF 2000).

Yet given the tremendous importance of education in containing the epidemic (World Bank 2002; UNAIDS 2004), it is imperative that policies be developed that encourage children to come to school and that there are targeted assistance programs for orphans (Evans and Miguel 2004). According to the World Bank (2002), basic education is "a window of hope" and is among the most effective and cost-effective means of HIV prevention. Education can also counter gender inequality, as girls who have been educated are more likely to be economically independent, delay marriage, work out of the house, do family planning, and have smaller families—all of which go far toward slowing the spread of HIV epidemic (World Bank 2002).

Increasing Awareness and Information Dissemination

There is a consensus that prevention programs need to be scaled up and be more effectively targeted. One of the overarching themes in the literature is the need for programs that target the less-educated and poorer populations of a country (Glick and Sahn 2005b). Because the epidemic is claiming more and more young people, there is also a need for culturally sensitive programs that appeal to the young. For example, video education, which addresses changing sexual patterns, has been highly successful (Davis and Stevenson 1994). Given that women are more vulnerable to the disease owing to lack of education, less access to information and health facilities, and less bargaining power within their partnerships to enforce safe sex methods, it is crucial that HIV/AIDS awareness programs are made more accessible to them as well. Other programs that enhance women's status and educational levels need to be implemented alongside HIV/AIDS awareness programs.

Awareness raising is also essential to combat HIV-related stigma and discrimination. The International Center for Research on Women identified four key kinds of HIV stigma indicators: (1) fear of casual transmission and refusal of contact with people living with HIV and AIDS; (2) values (shame, blame, judgment); (3) enacted stigma (discrimination); and (4) disclosure (ICRW 2006) Stigma may be increasingly linked to the sense of being burdened by a sick person in the context of declining household resources (Bond 2005).

Stigma and discrimination reduce an individual's willingness to practice prevention, seek HIV testing, disclose his or her HIV status to others, ask for (or give) care and support, and begin and adhere to treatment (ICRW 2006).

Changing Agricultural Policies and Programs

Agricultural policies need to change to meet two goals: one, to ensure that food and nutrition security policies and programs achieve their original objectives despite AIDS; and two, to contribute to the multisectoral response to HIV/AIDS. The following are some key action areas:

1. *Rural livelihoods.* Increase agricultural productivity of food-insecure farmers. Make markets work for the poor, and improve access to markets and infrastructure, such as roads. The emphasis should be on strengthening resilience that will allow households to recover from the shock of HIV/AIDS. A gender lens needs to be applied to such programs and projects, because the impacts of the HIV/AIDS epidemic vary for men's and

women's livelihoods. All livelihood programs should integrate the role of women as providers of food for their families.

2. *Social protection.* Reduce risk and vulnerability through appropriate safety nets, and, where required, provide food aid.
3. *Nutrition and human capital.* Improve the nutritional status of vulnerable groups. Ensure that public health and education policies support the poor—especially girls and women.
4. *Governance and capacity.* Foster good governance and public accountability, and develop capacity.
5. *Food assistance.* Food assistance should be targeted to people and families living with HIV/AIDS. The World Food Programme (WFP), for example, works with governments, NGOs, and other UN agencies to expand access to food and nutritional support for food-insecure people living with HIV and AIDS and their families in programs dealing with prevention of mother-to-child transmission of HIV, antiretroviral therapy, home-based care, and tuberculosis. WFP's programming in support of orphans and vulnerable children include school feeding, take-home rations, and awareness and education activities (WFP 2006).
6. *Micronutrients.* Provision of specific micronutrients, through fortified foods or supplements, to preserve immune function can improve the survival rates and quality of life of people living with HIV/AIDS.
7. *Breast-feeding.* Some programs are also trying promotion of exclusive breast-feeding based on selective risk assessment or household-level pasteurization of breast-milk before feeding.

Linking Nutrition and AIDS Policy

In April 2005 the WHO consultation on nutrition and HIV/AIDS ended with some key recommendations, including incorporating nutrition in national programs and policies; developing practical tools and guidelines for nutritional assessments for home, community, health facility–based, and emergency programs; expanding existing interventions for improving nutrition in the context of HIV; conducting systematic operational and clinical research to support evidence-based programming; strengthening, developing, and protecting human capacity and skills; and incorporating nutrition indicators into HIV/AIDS monitoring and evaluation plans (Gillespie 2006b). The recommendations include safe infant-feeding practices for HIV-infected women, micronutrients for pregnant and lactating women, and counseling and caring of women. Stillwaggon (2005) calls for health policies that address the underlying causes of the spread of HIV, such as risky environments that burden people with sickness and make them more vulnerable to HIV. She argues that a broad-based HIV prevention program will include deworming, schistosomiasis prevention and treatment, and malaria control programs in addition to food security.

Adopting Multisectoral Responses

Multisectoral responses are needed that integrate an understanding of gendered community and family dynamics and different vulnerabilities. Communities have developed a number of innovative ways of improving their resistance to the spread of HIV and their resilience to AIDS impacts, such as labor sharing, orphan support, community-based child care, community food banks (Gillespie and Kadiyala 2005). Although these responses are context-specific and address different impacts, there is a need to scale them up and make them multisectoral (Gillespie 2006b). The following are some examples of ongoing multisectoral initiatives in Sub-Saharan Africa.

Some multisectoral country programs are large in scale. For example, in Uganda, the National AIDS Control Program (NACP) is leading an inclusive process to develop and apply national guidelines for providing nutritional care and support to pregnant and lactating women with HIV/AIDS (Gillespie and Kadiyala 2005).

A few regional programs also exist, such as the Regional Network on HIV/AIDS, Rural Livelihoods, and Food Security (RENEWAL), composed of stakeholders from Malawi, South Africa, Uganda, Zambia, and recently Kenya. An evolving network of regional systems begun in 2001, RENEWAL undertakes activities related to three core principles: targeted action research, capacity strengthening, and policy communications. Facilitated by IFPRI, RENEWAL is developing processes through which decision makers at different levels and in

different contexts can use the HIV/AIDS lens in making policies (IFPRI 2006).

In 2000 the World Bank launched its Multi-Country HIV/AIDS Program (MAP) in Africa to support scaling up local responses. MAP has now committed US$1.2 billion to 29 countries and US$107 million to 4 subregional (that is, cross-border) projects. MAP's design is unprecedented in its flexibility, coverage, and emphasis on local, community-driven initiatives (Delion et al. 2004). The original objectives of the MAP program were to raise awareness, commitment, and resources for HIV/AIDS, support a multisectoral approach, stress community mobilization, and use alternative means to channel funds (World Bank 2006b). Gender has been integrated in a number of these MAP-supported local responses, but an interim review of MAP in 2004 found that although the original objectives are being realized, the outcomes of individual projects and subprojects have been mixed and often disappointing. Furthermore, the context for dealing with the epidemic in Africa has changed since MAP was started in 2000, and the World Bank needs to respond by making MAP more strategic, collaborative, and evidence-based (World Bank 2004).

Policies to combat HIV/AIDS need to be included in the development rhetoric because HIV/AIDS affects every stage of development. In many African countries, it has actually eroded development progress that has already been made, setting countries back years (World Bank 2002). The benefits of mainstreaming HIV/AIDS priorities into poverty-reduction strategies are manifold. It gives the epidemic greater political visibility and leadership, encouraging full government mobilization in the fight against HIV/AIDS and full governmental control over national AIDS programs. It will also ensure that more domestic resources are directed toward HIV/AIDS programs and will avoid too much dependency on donor-driven program design and financing (UNDP 2002).

The 2005 IFPRI conference highlighted that three overlapping and interacting sets of problems need to be kept in focus: HIV/AIDS, food insecurity, and malnutrition. The United Nations recognized these three priorities in June 2006 when Article 28 of the UN General Assembly Political Declaration on AIDS explicitly called for "all people at all times to have access to sufficient, safe, and nutritious food ... as part of a comprehensive response to HIV/AIDS." Achieving this kind of response calls for critically reviewing existing policies and programs through the lens of the growing knowledge on AIDS interactions, rather than pulling predesigned interventions off the shelf (Gillespie 2006b). Governments and international organizations need to work together to develop strategies for simultaneously strengthening community resilience and creating synergistic forms of state-led social protection (Gillespie 2006b). Not only is mainstreaming AIDS into development discourse and programs essential, but also the gendered vulnerabilities and impacts of HIV/AIDS must be integrated into responses to the epidemic.

Assignment

Given the rapid spread of the epidemic, increasing food insecurity, and increasing gender inequalities in Sub-Saharan Africa, your assignment is to recommend policies that will enhance awareness of HIV/AIDS among all groups, reduce women's vulnerability to the disease, and improve food security.

Additional Readings

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